PHARMACY REDESIGN PILOT PROGRAM ENROLLMENT

(Read Privacy Act Statement and Payment Instructions on back before completing this form.)

Form Approved OMB No. 0720-0023 Expires Jul 31, 2003

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0023), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for falling to comply with a collection of information if it does not display a currently valid OMB control number.

	EASE DO NOT RETURN YOUR FORM	I TO THE ABOVE ADDRESS	. RETURN	COMPLETED FORM	то т	HE APPROPRIATI	E ADDRESS C	ON BACK.	
	SPONSOR INFORMATION	1.		- OLUBITA		5 A TE OF BIRT			
a. NAME (Last, First, Middle)			SOCIAL SI	ECURITY	c. DATE OF BIRTH		-1	d. SEX (X one)	
			NUMBER		(YYYYMMDD)			MA	LE
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e.	DECEASED (X one)			f. SPONSOF	R ENF	ROLLING (X on	e)	•	
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					FALTILINGUDANCE (V				
	TELEPHONE NUMBERS (Include				HEALTH INSURANCE (X one				
(1) HOME (2) WORK			YES (If Yes, complete Item 3.			3.)			
				NO					
j.	IN CASE OF EMERGENCY, CON	ITACT: (2)	ADDRESS	(Street, City, Sta	ty, State, ZIP Code)		(3) 7	(3) TELEPHONE NUMBER	
(1)) NAME <i>(Last, First, Middle Initia</i>	al)					((Include area code)	
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2.	FAMILY MEMBER ENROLLMEN		ers reques	ting enrollment.	All ta	amily members	s must be re	gistered in	DEERS.)
	(Use additional pages if necess				(-)				
a.			SOCIAL SECURITY		(3) DATE OF BIRTH			(4) RELATIONSHIP TO	
			NUMBER		(YYYYMMDD)		5	SPONSOR	
	(5) ADDRESS (f different from sponsor) (Street, City, State, ZIP Code)		(6) TELEPHONE NUMBI		DS (If different from		(7) ((7) OTHER HEALTH	
				nsor) (Include are				INSURANCE (X one)	
	,		(a) HOME		(b) WORK		— 	 	
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	(8) IN CASE OF EMERGENCY, CONTACT: (b)			ADDRESS (Street, City, Sta		ate, ZIP Code)			E NUMBER
	(a) NAME <i>(Last, First, Middle In</i>	nitial)					((Include are	ea code)
h	b. (1) NAME (Last, First, Middle) (2		2) SOCIAL SECURITY		(3) DATE OF BIRTH		H (4) E	(4) RELATIONSHIP TO	
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			(a) HOME		(b) WORK			YES (If Yes, complete	
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	(8) IN CASE OF EMERGENCY, CONTACT: (b) (a) NAME (Last, First, Middle Initial)		TRUBICES (Street, Oily, St			ate, zii code)		(Include area code)	
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ა.	OTHER HEALTH INSURANCE	: (Complete only if you	nave otne.	r <u>HEALTH</u> INSURAI	nce.)				
a.	INSURANCE COMPANY NAME		TYPE OF COVERAGE		c. POLICY NUMBER		ER	d. EXPIRATION DATE	
	D.		(X one)					(YYYYMMDD)	
								,	,
			FULL						
			SUPPLEN						
e.	ADDRESS (Street, City, State, ZIP Code)		f. TELEPHONE NUMBER		g. DOES YOUR POLICY		OLICY HAVI	E PRESCRI	PTION DRUG
			(Include area co				X one)		
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1	SPONSOR OR ENROLLEE SIGN	IATLIDE			1	INO	5 DATE C	SIGNED /V	YYYMMDD)
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PRIVACY ACT STATEMENT

AUTHORITY: 44 USC Sec. 101; 10 USC 1079 and 1088; 38 USC Sec. 13; EO Sec. 387.

PRINCIPAL PURPOSE(S): To evaluate for medical care provided by civilian sources to Military Health Services beneficiaries applying for coverage under the TRICARE Program (32 CFR, Part 198.17).

ROUTINE USE(S): Information from application forms and related documents may be given to the Department of Defense, Health and Human Services, and/or Transportation consistent with their statutory administrative responsibilities under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made in the request of the person to whom a record pertains. Appropriate disclosure may be made to other Federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program.

DISCLOSURE: Voluntary; however, failure to provide information will result in denial of enrollment.

PAYMENT INSTRUCTIONS

Mail all TRICARE Pharmacy Redesign Pilot Program enrollment forms to:

Region 3 (Okeechobee, FL area)

Humana Military Healthcare Services Attn: Pharmacy Pilot Program Enrollment 500 West Main Street 515 Building, 3rd Floor P.O. Box 740072 Louisville, KY 40201-7472

Region 5 (Fleming, KY area)

Anthem Alliance Health Insurance Attn: Pharmacy Redesign Pilot Program Enrollment 333 W. First Street, Suite 210 Dayton, OH 45402

Complete credit card information below or attach a check or money order payable to **Anthem Alliance Health Insurance** or **Humana Military Healthcare Services** and include it with your enrollment form.

insurance of Figure 19 include Services and include it with your enrollment form.									
Credit Card:	Type Visa Credit Card Number Expiration Date (MMYY) Cardholder's Name	Master Card	Other						
	Cardholder's Signature			<u> </u>					
			have chosen, the number of pers 1_), and the total payment you a						
\$20	ual Payment Method: 0.00 per person per year.		(2) Semi-annual Payment Method: \$100.00 per person at the time of enrollmen and \$100.00 per person 6 months after each beneficiary is enrolled into the program.						
Reti	ree/Sponsor		Retiree/Sponsor	. •					
Retiree Family Member(s)			Retiree/Sporisor Retiree Family Member(s)					
Tota	al Payment \$		Total Payment	\$					